

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 440

## CERTIFICATE OF DEATH

Reg. Dist. No. 01567

## 1. PLACE OF DEATH:

County

Perryville, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

W. W. Married

60 years

B. (b) Name of husband or wife

Feb. 14, 1872

8. (c) If alive, give age

74 Years 5 Months Days If less than one day

9. Birthplace: Perry Co. Md.

(Town, county, and state)

10. Usual occupation: Farmer

## 11. Industry or business

Emmanuel Ansalvitch

12. Name: Mary soft

13. Birthplace: Perry Co. Md.

14. Maiden name: Mary soft

15. Birthplace: Perry Co. Md.

16. Informant: Perry Co. Md.

Address: Perryville, Md. Rural

17. Burial: Date thereof: Feb. 22, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Charlesstown

Location: Charlesstown, Md.

18. Funeral director: Ella Patterson &amp; Son

Address: Perryville, Md.

19. Date rec'd by registrar: Feb. 21, 1946

(Date rec'd by registrar) 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

Perryville, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. London Farms.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH:

February 19, 1946, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1, 1945, to Feb. 19, 1946

and that I last saw him alive on Feb. 19, 1946

Immediate cause of death: Lympho Leucoma or

Hodgkin's Disease

DURATION: 6 mos

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

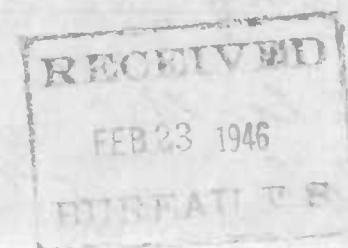
Means of injury: Injured at work?

23. SIGNATURE: J. F. Magaw

M. D. or other:

Address: Perryville Md. Date signed: 2/21/46

(Date rec'd by registrar) 1946



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33a

## CERTIFICATE OF DEATH

0150812  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

13 days

Hospital, institution, or street address where death occurred:

Union Hospital - Elkton - Md

How long in hospital or institution?

## 3. (a) FULL NAME

Jacob Dixon

Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Black widower

6. (b) Name of husband or wife

Julia Dixon

7. Birth date of

deceased (mo., day, yr.)

Dec 2, 1870

8. AGE:

Years

75

Months

2

Days

8

If less than one day

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

MOTHER

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

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FEB 16 1946

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 200-0

01509

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County

City or town

Eccles

Ecc

RECEIVED

FEB 21 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age  
of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

FILM No. 100 FEB 12 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 11510

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hospital

How long in hospital or institution?

5 days

3. (a) FULL NAME

Elizabeth Ledy Gerald

3. (b) Social Security Number

none

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

White

Widowed

6. (b) Name of husband or wife

George W. Fitzgerald

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Sep 23 - 1861

If alive, give age

8. AGE:

Years

84

Months

8

Days

4

If less than one day

hrs.

min.

9. Birthplace

North East Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

William Reed

MOTHER

Maryland

12. Name

William Reed

13. Birthplace

Maryland

14. Maiden name

Ferguson

15. Birthplace

Maryland

16. Informant

Ada Reed

Address

Elkton Md

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

Feb 7 1946  
(month) (day) (year)

Cemetery or crematory

Rosebank

Location

Calvert Md

18. Funeral director

Joseph A. Chan

Address

North East Md

19. (Date rec'd by registrar)

Feb 6 1946

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 4 1946 at 9:55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 30 1946 to Feb 4 1946  
and that I last saw her alive on Feb 3 1946

Immediate cause of death

Pneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

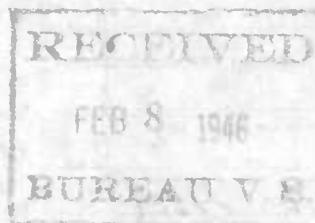
M. D. or other

Address

Date signed

RECEIVED TO FEDERAL BUREAU OF INVESTIGATION

RECEIVED TO FEDERAL BUREAU OF INVESTIGATION





# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

## Example II

Other contributory causes of importance:

Gallstones	May 1, 1923

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

01512

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

CECIL

County

City or town VETERANS ADMINISTRATION, PERRY POINT, MD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 9 mo. 30 days

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

## 3. (a) FULL NAME

FREELAND, Daniel Jr.

## 4. Sex

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Male

White

Single

## 6. (b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

1-29-1888

## 8. (c) If alive, give age

years

## 8. AGE:

Years

Months

Days

If less than one day

58

8

-

-

-

hrs.

-

min.

## 9. Birthplace

Washington, D.C.

(Town, county, and state)

## 10. Usual occupation

Painter

## 11. Industry or business

-

12. Name

Daniel Freeland

FATHER

Baltimore, Md.

## 14. Maiden name

Frances Freeland

MOTHER

Baltimore, Md.

## 16. Informant

Hospital Records

## Address

Veterans Administration, Perry Point, Md.

## 17. Removal

## Date thereof

2-7-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Washington National Cemetery

## Location

Maryland

## 18. Funeral Director

Pennington &amp; Son, Havre de Grace, Md.

## Address

19. Feb. 7 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

D.C.

County

Washington

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

706 11th Street, N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

W.W. I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

February 6,

19. 46

at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DEK. April 7

1937

to February 6 1946

and that I last saw h. alive on

19...

Immediate cause of death

Chronic Myocarditis,

Undetermined

DURATION

6/1/ Arteriosclerosis, general Over 7 years

Due to

Other conditions Mental Deficiency without

psychosis

Lifetime

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

-

Means of Injury

Injured at work

## 23. SIGNATURE

H. E. TROLLINGER Lt. Col. M.C.

M. D. or other

Acting Manager

Veterans Administration

Date signed 2-7-46

Perry Point, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

01513

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

## 1. PLACE OF DEATH:

County Cecil CoCity or town Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 yrsHospital, institution, or street address where death occurred: Elkton Md P.D. 3

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Harry Gallagher4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Osvaldo Gallagher7. Birth date of deceased (mo., day, yr.) Mar 11 - 1866 6. (c) If alive, give age 73 years8. AGE: Years 79 Months 11 Days 15 If less than one day hrs. min.9. Birthplace near Fair Hill Cecil Co Md  
(Town, county, and state)10. Usual occupation Blacksmith

11. Industry or business

12. Name Julian J. Gallagher13. Birthplace Cecil Co Md14. Maiden name Mary McCray15. Birthplace Wyo Re Croy16. Informant Mrs. Mollie GallagherAddress Elkton Md P.D. 317. Burial, cremation, or removal. Which? Burial Date thereof Mar 1 1946

(month) (day) (year)

Cemetery or crematory Cherry HillLocation Cherry Hill18. Funeral director R. T. JonesAddress Newark Del19. Date rec'd by registrar Feb 27 1946

(Data rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Rural (If outside city or town limits, write RURAL and give nearest town)Street No. Elkton Md P.D. 3 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 26 1946 at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

14 Jan 1946 to 26 Feb 1946

and that I last saw him alive on 25 Feb 1946

Immediate cause of death Cerebral hemorrhage DURATION 36 hrs.Due to arteris-sclerosis 15 yrs.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings or operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harmon Johnson M. D. or other \_\_\_\_\_Address Newark Del Date signed 26 Feb 46

MEMORANDUM FOR THE SECRETARY OF STATE  
RECEIVED BY THE SECRETARY OF STATE

MEMORANDUM FOR THE SECRETARY OF STATE  
RECEIVED BY THE SECRETARY OF STATE

RECEIVED

MAR 2 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 40

## CERTIFICATE OF DEATH

01514

Reg. Dist. No.

46

## 1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Port Deposit Rural

How long in above place of death?

Hospital, institution, or street address where death occurred:

Stanley Nursing Home

Now long in hospital or institution? 2 mo 16 days

## 3. (a) FULL NAME

William Silliman

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife.....

None

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

no accurate information

8. AGE: Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER

12. Name.....

13. Birthplace

14. Maiden name.....

15. Birthplace

16. Informant.....

Address

17. (Burial, cremation, or removal? Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. (Date rec'd by registrar)

## CERTIFICATE OF DEATH

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County.....

Cecil

City or town.....

Cecilton

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

February 16 1946 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 10 1945 Feb 24 1946  
and that I last saw him alive on Feb. 24 1946

Immediate cause of death.....

Carcinoma of the  
breast

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

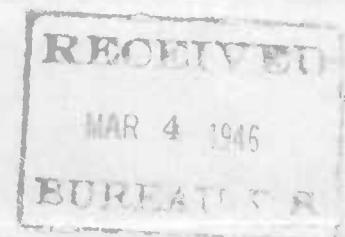
B. J. Johnson M.D.

Port Deposit

Md

Date signed 7/27/46

Address



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

01515

## 1. PLACE OF DEATH

County CecilVillage or City North East

No. \_\_\_\_\_

Registration Dist. No. 94

St. \_\_\_\_\_

Ward \_\_\_\_\_

Length of residence in city or town where death occurred 45 yrs.(If death occurred in a hospital or institution, give its NAME instead of street and number)  
mos. \_\_\_\_\_ ds. How long in U. S. if of foreign birth? yrs. \_\_\_\_\_ mos. \_\_\_\_\_

## 2. FULL NAME

William Hawkins(a) Residence: No. North East Md

(Usual place of abode)

St. \_\_\_\_\_

Ward. \_\_\_\_\_

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male Colonel Married

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced

HUSBAND of  
(or) WIFE ofNora Hawkins

6. DATE OF BIRTH (month, day, and year)

Oct 8 1900

7. AGE

Years 43 Months 4 Days 7 If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.  
Chauffeur

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town)

(State or country) Baltimore Cecil Co. Md

MOTHER

FATHER

13. NAME William P Hawkins

14. BIRTHPLACE (city or town)

(State or country) North Carolina

15. MAIDEN NAME

Edith Bocome

16. BIRTHPLACE (city or town)

(State or country) Rolling Acres

17. INFORMANT

(Address) Edith Hawkins

18. BURIAL, CREMATION, OR REMOVAL

Place Cedar Hill, Md Date Feb 18, 1946

19. UNOERTAKER

(Address) Joseph R. HartNorth East Md20. FILED 2/18, 1946 Lida & Louise

Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Feb.15(Month) Year

22. I HEREBY CERTIFY. That I attended deceased from

2-11, 1946, to 2-18, 1946I last saw him alive on 2-15, 1946; death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Pulmonary Tuberculosis about 1 year

Other Contributory Causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? Yes

If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19

Where did injury occur? \_\_\_\_\_ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?

If so, specify \_\_\_\_\_

(Signed) Maude L. Lewis M.D.(Address) Naure de Grace, Md

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

Arteriosclerosis  
Chronic interstitial nephritis  
Cerebral hemorrhage

Date of onset

1915

1921

July 5, 1927

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy  
Run over by street car

Peritonitis

Date of onset

1 week ago

1 week ago

3 days ago

Other contributory causes of importance:

Gallstones

May 1, 1923

Other contributory causes of importance:

Gastroenteritis

1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

## CERTIFICATE OF DEATH

01516

92

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

City or town.....

Cecil  
Elkton, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 yr. 3

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

H. White Single

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Nov 1944

8. (c) If alive, give age..... years

8. AGE:

Years 1 Months 3 Days 13 If less than one day hrs. mto.

9. Birthplace.....

Elkton, Maryland

(Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

FATHER

12. Name..... John E. Hollenbaugh

13. Birthplace

Shippensburg, Pa.

MOTHER

14. Maiden name..... Anna P. Clair

15. Birthplace

Clampfield, Pa.

16. Informant.....

Mr. John E. Hollenbaugh

Address

292 Hollingsworth, Monrovia, Md.

17. Removal

(Burial, cremation, or removal, Which?)

Date thereof..... Feb 8/46

Cemetery or crematory.....

Shippensburg, Pa.

Location.....

Shippensburg, Pa.

18. Funeral director.....

H. W. Pipkin

Address

Elkton, Md.

19. Feb 6

1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Delaware County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

292 Hollingsworth, Monrovia, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 5 1946, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Lobage

Due to.....

Pneumonia

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

Medical Examiner  
for Cecil County

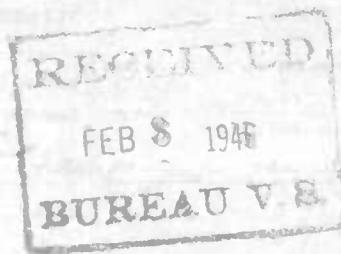
M. D. or other

Date signed

Feb 5 1946

Address.....

Date signed.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 303

## CERTIFICATE OF DEATH

Reg. Dist. No. 01517

1. PLACE OF DEATH: CecilCounty CecilCity or town Chesapeake City  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yearsHospital, institution, or street address where death occurred: Chesapeake CityHow long in hospital or institution? Chesapeake City

## 3. (a) FULL NAME

William Hrycek4. Sex M 5. Color or race wh 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife: None7. Birth date of deceased (mo., day, yr.) June 23, 1923 6. (c) If alive, give age years8. AGE: 22 Years 7 Months 21 Days If less than one day hrs. min.9. Birthplace Chesapeake City, Md.  
(Town, county, and state) Austria10. Usual occupation: None11. Industry or business: None12. Name John Hrycek  
MOTHER FATHER13. Birthplace Austria14. Maiden name Kathryn Hamoyczak  
MOTHER15. Birthplace Austria16. Informant Mrs. John Hrycek  
Address Chesapeake City, Maryland17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 14, 46  
(month) (day) (year)Cemetery or crematory Chesapeake Catholic CentLocation Chesapeake City, Md.18. Funeral director H. W. Pippin  
Address Elkton, Md.19. Deathmark 14 1946 Mrs. Ralph H. Pippin  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County CecilCity or town Chesapeake City, Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. None  
(If rural, give LOCATION)2. (a) If veteran, name war: None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1946

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

not 1936 to Feb. 12 1946and that I last saw h. alive on Feb 12 1946Immediate cause of death: Tertiary SyphilisDue to: NoneDue to: NoneOther conditions: None

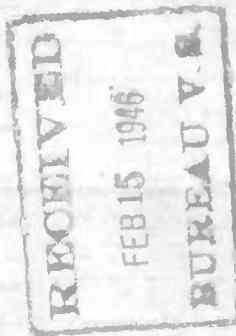
(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op. NoneAutopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of NoneWhere did injury occur? None (City or town) None (County) None (State)Injured at home, farm, industry, public place (where?) NoneMeans of injury None Injured at work? None23. SIGNATURE H. W. Pippin M. D. or other NoneAddress Elkton, Md. Date signed 2/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 230

01518

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County

City or town

Cecil  
Carroll

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

2 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Hester Ann Hustell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

W

Widowed

6. (b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.)

Jan. 21 1861

6. (c) If alive, give age years

8. AGE:

Years  
85

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

MOTHER FATHER

Benjamin George

13. Birthplace

Maryland

14. Maiden name

Margaret Edwards

15. Birthplace

Maryland

16. Informant

Mrs. Charles A. Craig

17. Burial

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof  
(month) (day) (year)

20. Usual residence (HOME) of deceased:

(For newborn infants give residence of mother)

State

City or town

Md. Carroll

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2. (a) If veteran, name war

(If rural, give LOCATION)

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 15 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9:30 A.M. 1946 to 9:30 A.M. 1946

and that I last saw her alive on 9:30 A.M. 1946

Immediate cause of death

Hysteria

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

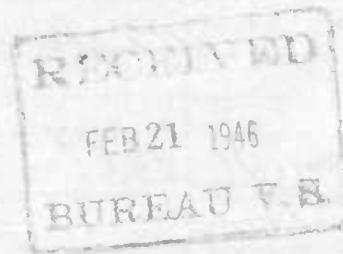
Means of injury Injured at work?

23. SIGNATURE G. L. Copeland M. D. or other

Address Millington Date signed Feb. 18, 1946

Feb. 18, 1946

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 483

## CERTIFICATE OF DEATH

Reg. Dist. No. 11519

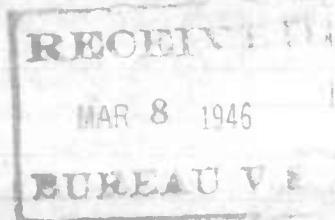
1. PLACE OF DEATH: Cecil  
 County.....  
 City or town..... Elkton, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 37 years  
 Hospital, institution, or street address where death occurred: Union Hospital  
 How long in hospital or institution?..... 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... Cecil  
 City or town..... Rural Near Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Elkton, RD5 s. Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Lillian B. Jackson Jackson  
 4. Sex F 5. Color or race Wh. 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife..... James H. Jackson  
 7. Birth date of deceased (mo., day, yr.) July 16, 1908 8.(c) If alive, give age..... years  
 8. AGE: Years 37 Months 7 Days 12 If less than one day  
 hrs. ..... min.  
 9. Birthplace..... Fair Hill, Cecil Co., Md.  
 (Town, county, and state)  
 10. Usual occupation..... At Home  
 11. Industry or business.....  
 12. Name..... John P. Anderson  
 MOTHER FATHER  
 13. Birthplace Lewisville, Pa.  
 14. Maiden name..... Annie L. Wicks  
 15. Birthplace Pleasant Hill, Md.  
 16. Informer..... James H. Jackson  
 Address Elkton, RD 5, Md.  
 17. Burial Burial Date thereof Mar 3 '46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Friends  
 Location..... Calvert, Md.  
 18. Funeral director R. H. Lippin  
 Address Elkton, Md.  
 19. Date rec'd by registrar Mar 2 1946 F. P. Fagan  
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number.....  
 MEDICAL CERTIFICATION  
 20. DATE OF DEATH Feb. 16 <sup>a</sup> 1946 at 12:45 <sup>m</sup>  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 <sup>a</sup> 1946, to Feb. 26 <sup>a</sup> 1946, and that I last saw h. alive on Feb. 21 <sup>a</sup> 1946  
 Immediate cause of death..... Concretions - Cerebral  
 Due to..... Barbiturates of  
 Cerebrum  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)  
 Major findings of operations..... Date of op.  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?  
 23. SIGNATURE Jean Jackson M. D. or other  
 Address..... Elkton, Md. Date signed Mar 2 1946

RECEIVED FROM THE STATE DEPARTMENT  
BY THE STATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore. 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:  
 County..... Cecil  
 City or town..... Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 15 years  
 Hospital, institution, or street address where death occurred:  
224 W. High St.  
 How long in hospital or institution?.....

3. (a) FULL NAME  
MARY R. JOHNSTON

4. Sex F 5. Color or race Wh 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Percy S. Johnston  
 7. Birth date of deceased (mo., day, yr.) Feb. 9 1861 6. (c) If alive, give age ..... years  
 8. AGE: Years 84 Months 11 Days 27 If less than one day ..... hrs. ..... min.  
 9. Birthplace Belfast Pa  
 (Town, county, and state)  
 10. Usual occupation at home

11. Industry or business  
 MOTHER FATHER 12. Name William Gleach  
 13. Birthplace Belfast Pa  
 MOTHER 14. Maiden name Mary Duncan  
 15. Birthplace Belfast Pa  
 16. Informant Wm MacLane Johnston  
 Address Elkton, Maryland

17. Burial Burial Date thereof Feb. 8 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arlington  
 Location Fansdown Pa  
 "Highspire"

18. Funeral director Hopkinson  
 Address Elkton, Md.  
 19. Date rec'd by registrar Feb 7 1946 19. Date rec'd by registrar Feb 7 1946 3 R. Fraser  
 (Date rec'd by registrar) (Date rec'd by registrar) (Signature) (Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Cecil  
 City or town Elkton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 224 West High  
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1946 at 8:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1944 to Feb. 5 1946 and that I last saw her alive on Feb. 5 1946

Immediate cause of death Bronchitis-pneumonia DURATION Feb. 2

Due to.....

Due to.....

Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Oneford W. Sonader, Jr. M. D. or other

Address Elkton, Md. Date signed 2/6/46

EEBT 6 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23d

## CERTIFICATE OF DEATH

Reg. Dist. No. 11592

1. PLACE OF DEATH: *Cecil*County *Elkton*City or town *Elkton*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *81 years*Hospital, institution, or street address where death occurred: *Union Hospital*How long in hospital or institution? *1 week*

## 3. (a) FULL NAME

*Donna Belle Lewis*

4. Sex

5. Color or race *wh.*6. (a) Single, married, widowed, or divorced *Widowed*8. (b) Name of husband or wife *Henry A. Lewis*

7. Birth date of deceased (mo., day, yr.)

*Nov. 17, 1858*

6. (c) If alive, give age years

8. AGE:

Years *87* Months *3* Days *11* If less than one dayhrs.  min. 

9. Birthplace

*Elkton, Md*

(Town, county, and state)

10. Usual occupation

*at home*

11. Industry or business

*James Walker*12. Name *James Walker*13. Birthplace *Elkton, Md*14. Maiden name *Mary Elizabeth Harrott*15. Birthplace *Elkton, Md*

16. Informant

*Mrs. Edward Lewis*Address *Elkton, Md*

17. Burial

Date thereof *Nov. 1, 1946*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *Elkton*Location *Elkton, Md*18. Funeral director *H. W. Lipkin*Address *Elkton, Md*19. Date rec'd by registrar *Feb. 25, 1946*Registrar *H. Frazer*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md*County *Cecil*City or town *Pauline near Elkton*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *R.D. 3*

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*February 26, 1946, at 6:45 P.M.*21. CERTIFY that death occurred on the date above stated; that I attended deceased from *February 19, 1946, to February 26, 1946* and that I last saw her *alive* on *February 26, 1946*.

Immediate cause of death

*cardiac exhaustion*

DURATION

Due to

*chronic myocarditis*

7

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

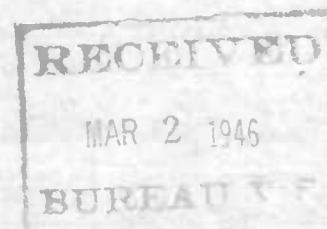
Injured at work?

23. SIGNATURE

*James G. Gresham, M.D.*

M. D. or other

Address *Elkton, Md*Date signed *Feb. 26, 1946*





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 232

## CERTIFICATE OF DEATH

Reg. Dist. No. 0152296

## 1. PLACE OF DEATH:

County..... CecilCity or town..... Veterans Administration, Perry Point, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs. 28 days

Hospital, Institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.How long in hospital or institution? Same as above

## 3. (a) FULL NAME

MC LAREN, John

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Male White

Single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

October 22, 1876

## 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

69327

..... hrs.

..... min.

9. Birthplace..... Scotland

(Town, county, and state)

10. Usual occupation..... Sailor

## 11. Industry or business

12. Name..... John McLaren13. Birthplace Scotland14. Maiden name..... Mary McLaren (Maiden name unknown)15. Birthplace New York16. Informant..... Hospital RecordsAddress Veterans Administration, Perry Point, Md.

## 17. Burial.....

(Burial, cremation, or removal. Which?) Burial Date thereof..... 2/22/46

(month) (day) (year)

Cemetery or crematory Angel HillLocation Havre de Grace, Md.18. Funeral director..... Pennington & Son, Havre de Grace, Md.

Address

19. Date rec'd by registrar Feb. 20, 1946

(Date rec'd by registrar)

June 7, 1946

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 608 E. Pratt Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish American War

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH February 18

19 46 at 9:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 21

19 42 to February 18 19 46

and that I last saw him alive on February 18 19 46

## Immediate cause of death

Myocardial Damage

Over 4 years

Due to Arteriosclerosis, Coronary

11 11 11

Due to

Other conditions Psychosis with Cerebral Arteriosclerosis

Over 4 years

(Include pregnancy within 3 months of death)

## Major findings or operations

Date of op.

Autopsy results Not performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?)

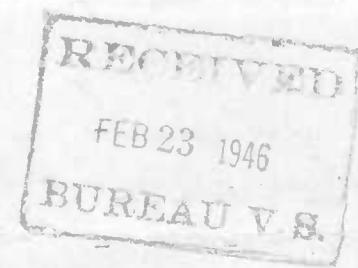
Means of injury

Injured at work

## 23. SIGNATURE

A. E. Trolling  
A. E. TROLLINGER, Lt. Col., M.C., C.M., Major, Director, Veterans Administration, Perry Point, Md.

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

01523

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County..... *Cecil*City or town..... *Warwick*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... *66 yrs*

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

*Richard Boulton**Bennett Jr*

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*Male**White Married**Married*

6. (b) Name of husband &amp; wife

*Hedda M. Bennett*

7. Birth date of deceased (mo., day, yr.)

*2-5-1880*

8. (c) If alive, give age 35 years

8. AGE:

*66*

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

*Warwick Md.*

(Town, county, and state)

10. Usual occupation

*Retired Merchant*

11. Industry or business

*Richard B. Bennett*

MOTHER FATHER

12. Name

MOTHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Date thereof. *3-3-46*

(month) (day) (year)

*Burial**Warwick Md.**St. Peter's Angels**Richard Boulton**Mar. 25, 1946*

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

*Jan 1, 1946* 1946 at *10:45* AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Jan 1, 1946* 1946 to *Jan 28, 1946* 1946 and that I last saw him alive on *Jan 27, 1946* 1946

Immediate cause of death.....

*Chronic nephritis**Pressia*

DURATION

*6 Months**3 Weeks*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE

*Walter R. Lee*

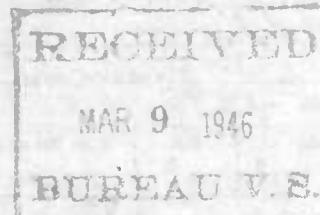
M. D. or other

Address.....

*Woodlawn Hospital*Date signed *3/1/46*

MEMO TO THE SENIOR STATE ATTORNEY

MEMO TO THE SENIOR STATE ATTORNEY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

01524

## CERTIFICATE OF DEATH

96

Reg. Dist. No. 

## 1. PLACE OF DEATH:

Cecil

County

Perry Point, Maryland

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 9 mos. 12 days

Hospital, institution, or street address where death occurred:

Veterans Administration Hospital

How long in hospital or institution? 2 yrs. 9 mos. 12 days

## 3. (a) FULL NAME

MILLER, John J.

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife. Mrs. Lena C. Miller

7. Birth date of deceased (mo., day, yr.)

April 2, 1875

6.(c) If alive, give age ? years

## 8. AGE:

Years

Months

Days

If less than one day

70

10

26

hrs. min.

9. Birthplace. Baltimore, Md.

(Town, county, and state)

10. Usual occupation.

Farmer

11. Industry or business Farming

MOTHER FATHER

12. Name. John Miller

MOTHER FATHER

13. Birthplace Pennsylvania

14. Maiden name

Mary (?) Miller

MOTHER FATHER

15. Birthplace Pennsylvania16. Informant Records, Vets. Adm. Hospital

Address

Perry Point, Md.17. Burial BurialDate thereof. 3-4-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rockwood CemeteryLocation Baltimore, Md.

18. Funeral director

PENNINGTON & SON

Address

Havre de Grace, Md.19. March 2 19 46 John E. Daugherty

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State. MarylandCounty. BaltimoreCity or town. Essex, Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mt. Hays, Rustic Ave. & Phila. Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war. Spanish-American

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

February 28

19 46 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1943 to February 28 1946

and that I last saw him alive on February 28 1946

Immediate cause of death

Myocardial Degeneration

DURATION

Due to. Coronary Arteriosclerosis

over 3 yr.

Due to.

Other conditions Psychosis w/cerebral arteriosclerosis" Arteriosclerosis, general

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

A. E. TROLLINGER, LT. COL., M.M., DOL, D.D.S.

Address. VAH, Perry Point, Md.

Date signed 3-2-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and briefly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33-2

## CERTIFICATE OF DEATH

01525

94

Reg. Dist. No.

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

46 years

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
83	8	15	hrs. min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

Walney Clemon

Pearl

Pearl

13. Birthplace.....

Savannah Rotimare

14. Maiden name.....

Savannah Rotimare

15. Birthplace.....

Eleston Md.

Eleston Md.

Eleston Md.

Eleston Md.

Eleston Md.

16. Informant.....

Mrs. Montgomery

North East Md.

Address.....

Burial

(Burial, cremation, or removal. Which?)

Date thereof: Dec 5 1946

(month) (day) (year)

Cemetery or crematory.....

Hypewee Methodist

Location.....

Port Deposit, Md. RD

18. Funeral director.....

Joseph B. Clemon

Address.....

Duluth, Md.

19. 2/2 1946

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 25 1946 to Feb 2 1946

and that I last saw her alive on Feb 1 1946

Immediate cause of death.....

Acute Cardiac

Necrotic

Due to.....

Fainting

Bronchitis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE

Address..... Date signed 2-2-46

M. D. or other

RECEIVED

FEB 6 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 370

01526

## CERTIFICATE OF DEATH

Reg. Distr. No. 96

## 1. PLACE OF DEATH:

CECIL

County

City or town Veterans Administration, Perry Point, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs. 4 mo. 20 da.

Hospital, institution, or street address where death occurred:

Veterans Administration, Perry Point, Md.

How long in hospital or institution? Same as above

## 3. (a) FULL NAME

MORGAN, William F.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mrs. Mabel Morgan

7. Birth date of deceased (mo., day, yr.)

January 12, 1899

6. (c) If alive, give age Unknown years

8. AGE:

Years

Months

Days

If less than one day

47

21

—

hrs.

—

min.

9. Birthplace

Pennsylvania

(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

MOTHER FATHER

12. Name

Unknown

MOTHER

13. Birthplace

Unknown

FATHER

14. Maiden name

Mrs. Mary Liebig

MOTHER

15. Birthplace

Unknown

16. Informant

Hospital Records

Address

Veterans Administration, Perry Point, Md.

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 4, 1946  
(month) (day) (year)

Cemetery or crematory

Holy Sepulchre

Location

Philadelphia, Pa.

18. Funeral director

Pennington &amp; Son

Address

Havre de Grace, Md.

19. Date

4

19. 46

Date rec'd by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Elkton

(If outside city or town limits, write RURAL and give nearest town)

Street No. East High Street

(If rural, give LOCATION)

2. (a) If veteran, name war

W.W. I

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

February 2

19 46

at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 13 19 22 to February 2 19 46

and that I last saw him alive on February 2 19 46

Immediate cause of death

Encephalitis Lethargica, Residuals of Parkinsonian Syndrome

Over 23

yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Not performed

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

—

Injured at work?

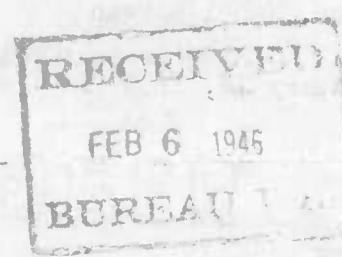
23. SIGNATURE

F. TROLLINGER, Lt. Col., M.C., U.S.A.  
Director, Veterans Administration Clinical

Address

Perry Point, Md.

Date signed 2-4-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

01527

## CERTIFICATE OF DEATH

Reg. Dist. No. 94

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Cecil  
County.....

City or town..... North East, Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 25 years  
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME John C. Rainie

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Effie J. Rainie

7. Birth date of deceased (mo., day, yr.) July 11 1875

8. AGE: Years 70 Months 7 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Penns  
(Town, county, and state)

10. Usual occupation Machinist

11. Industry or business Penna R.R.

12. Name John Rainie

13. Birthplace Penna

14. Maiden name Sarah E. Oss

15. Birthplace Penna

16. Informant Charles Rainie

Address North East, Md

17. Burial Burial Date thereof 2-20-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Q. Ford

Location Afford Penna

18. Funeral director Joseph R. Rainie

Address North East, Md

19. 2/20 1946 Lida & Cervos  
(Date rec'd by registrar) (Date) (Name of witness)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md County Cecil

City or town North East, Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number 716-01-8555

## MEDICAL CERTIFICATION

20. DATE OF DEATH 2-17- 1946, at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1946 to 2-17-1946

and that I last saw him alive on 2-16-1946

Immediate cause of death.....

Complications of  
stroke

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. \_\_\_\_\_

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of \_\_\_\_\_

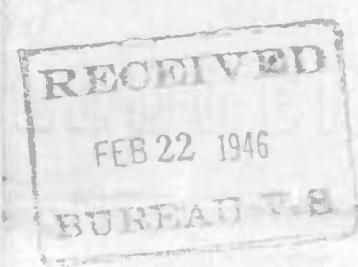
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John H. H. Rainie M. D. or other \_\_\_\_\_

Address 86th St Date signed 2/19/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 01531

## 1. PLACE OF DEATH?

County

City or town

Belleville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ruth Mary Russell

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

White Married

6. (b) Name of husband or wife

Samuel S. Russell

8. (c) If alive, give age

59 years

7. Birth date of

deceased (mo., day, yr.)

Aug 3 1897

8. AGE:

Years

Months

Days

If less than one day

48

5

1

hrs.

min.

9. Birthplace

Philadelphia Pa

(Town, county, and state)

10. Usual occupation

H.V.M.

11. Industry or business

MOTHER

Harry H. Slocum

FATHER

Baltimore Md

13. Birthplace

Baltimore Md

14. Maiden name

Surrey Slocum

15. Birthplace

Philadelphia Pa

16. Informant

Samuel S. Russell

Address

Baltimore Md

17. Burial

Feb 7, 1946

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Harmon Chapel

Location

Baltimore Md

18. Funeral director

J. C. Tyson

Address

Baltimore Md

19. Certified by registrar

Feb 6 1946

Date signed

2-6-46

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

2261

County

Cecil

City or town

Baltimore Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 4 1946 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h... alive on

19...

Immediate cause of death

acute coronary

DURATION

Due to

Thrombosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Medical Examiner  
Cecil County

M. D. or other

Address

Baltimore Md

Date signed 2-4-46



RECEIVED

FEB 20 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

01529

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

## 1. PLACE OF DEATH:

County

City or town

Port Deposit Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

51 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William J. Todd

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Married

6. (b) Name of husband or wife

Edna Todd

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

51

years

Feb. 9 1892

8. AGE:

Years

Months

Days

If less than one day

54

6

hrs.

min.

9. Birthplace

Lewellen, Md

(Town, county, and state)

10. Usual occupation

Dragon Stone

11. Industry or business

Lewellen, Md

FATHER

12. Name

James C. Todd

13. Birthplace

Pa.

MOTHER

14. Maiden name

Caroline Nelson

15. Birthplace

Cecil Co. Md

16. Informant

Edna Todd

Address

Port Deposit Rd, Md

17. Burial

Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Feb. 18 1946

Cemetery or crematory

West Nottingham

Location

Calera, Md

18. Funeral director

W. A. Patterson

Address

Perryville, Md

19. Date rec'd by registrar

19

Date

Edna E. Daugherty

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

2 - 15 1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

19.

and that I last saw him alive on

19.

Immediate cause of death

Coronary

Due to

Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Pleasanton, Md

M. D. or other

Date signed

2 - 15 - 46

STANISLAVSKY STAFF OPERATIONS

RECEIVED  
MAY 20 1946

BUREAU OF INVESTIGATION